



## CHECKLIST TO DETERMINE ACCREDITING AUTHORITY COMPLIANCE

AA Applicant Name:

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NELAP Certificate No.

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Date Reviewed:

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Reviewed By

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**Note: Based on 2001 and 2003 NELAC Standards:** Most NELAC requirements identified on this checklist are a paraphrase of the NELAC standard. The number preceding each checklist item is the location in the NELAC standards where the exact language for that requirement can be found.

NELAC Requirements of an Accrediting Authority					
	AA:	Yes	No	NA	Document Location/Comments
<b>A. The accrediting authority's program requires accredited laboratories to meet the following NELAC standards:</b>					
1	2.2.3 Laboratories that seek to become accredited or maintain accreditation shall perform analyses of PT samples for each field of proficiency testing as defined in Section 2.1.3. The laboratory shall obtain PT samples from designated PTOB/PTPA-approved PT Providers. The results of the analyses shall be submitted to the PT Provider for scoring.				
2	2.2.4 Accrediting Authorities shall accept for the purposes of initial and continuing accreditation, PT results from any designated PTOB/PTPA-approved PT provider that meets the requirements of this standard.				
3	2.4.1 To be accredited initially and to maintain accreditation, a laboratory shall participate in two single-blind, single concentration PT studies, where available, per year for each field of proficiency testing for which it seeks or wants to maintain accreditation. Laboratories must obtain PT samples from a PTOB/PTPA-approved PT provider. Each laboratory shall participate in at least two PT studies for each field of proficiency testing per year unless a different frequency for a given program is defined in the appendices.				
4	2.4.2 At the time each laboratory applies for accreditation, it shall notify the Primary Accrediting Authority which field(s) of testing it chooses to become accredited for and shall participate in the appropriate PT studies.				
5	2.4.3 Each laboratory shall authorize the PT Provider to release all accreditation and remediation results and acceptable/not acceptable status directly to the Primary Accrediting Authority, and the PTOB/PTPA, in addition to the laboratory.				
6	<p>2.5 The samples shall be analyzed and the results returned to the PT Provider no later than 45 calendar days from the opening of the study. The laboratory's management and all analysts shall ensure that all PT samples are handled (i.e., managed, analyzed, and reported) in the same manner as real environmental samples utilizing the same staff, methods as used for routine analysis of that analyte, procedures, equipment, facilities, and frequency of analysis.</p> <p>When analyzing a PT sample, a laboratory shall employ the same calibration, laboratory quality control and acceptance criteria, sequence of analytical steps, number of replicates and other procedures as used when analyzing routine samples.</p>				
7	2.5.1 (a) A laboratory shall not send any PT sample, or a portion of a PT sample, to another laboratory for any analysis for which it seeks accreditation, or is accredited.				
8	2.5.1 (b) A laboratory shall not knowingly receive any PT sample or portion of a PT sample from another laboratory for any analysis for which the sending laboratory seeks accreditation, or is accredited.				
9	2.5.1 (c) Laboratory management or staff shall not communicate with any individual at another laboratory (including intracompany communication) concerning the PT sample.				

10	2.5.1 (d) Laboratory management or staff shall not attempt to obtain the assigned value of any PT sample from their PT Provider.				
11	2.5.2 The laboratory shall maintain copies of all written, printed, and electronic records, including but not limited to bench sheets, instrument strip charts or printouts, data calculations, and data reports, resulting from the analysis of any PT sample for five years or for as long as is required by the applicable regulatory program, whichever is greater. These records shall include a copy of the PT study report forms used by the laboratory to record PT results. All of these laboratory records shall be made available to the assessors of the Primary Accrediting Authority during on-site audits of the laboratory.				
12	2.7.2 A laboratory seeking to obtain or maintain accreditation shall successfully complete two initial or continuing PT studies for each requested field of proficiency testing within the most recent three rounds attempted. For a laboratory seeking to obtain accreditation, the most recent three rounds attempted shall have occurred within 18 months of the laboratory's application date.				
13	2.7.2 When a laboratory has been granted accreditation status, it shall continue to complete PT studies for each field of proficiency testing and maintain a history of at least two acceptable PT studies for each field of proficiency testing out of the most recent three.				
14	2.7.2 For initial accreditation, the laboratory must successfully analyze two sets of PT studies, the analyses to be performed at least 15 calendar days apart from the closing date of one study to the shipment date of another study for the same field of proficiency testing.				
15	2.7.2 For continuing accreditation, completion dates of successive proficiency rounds for a given field of proficiency testing shall be approximately six months apart. Failure to meet the semiannual schedule is regarded as a failed study.				
16	2.7.3 A NELAP-accredited laboratory may elect to participate in supplemental PT studies when the laboratory desires to add field(s) of proficiency testing to their scope or when the laboratory fails an initial or continuing PT study and wishes to re-establish its history of successful performance. These additional studies are not distinguished from the initial or continuing PT studies except that: analysis dates of supplemental PT studies must be at least 15 calendar days apart from the closing date of one study to the shipment date of another study for the same field of proficiency testing. For supplemental studies laboratories report to their PT Provider results for all analytes for which they are demonstrating corrective action or requesting an expansion of their existing accreditation.				
17	2.7.3.1 A NELAP accredited laboratory is required to maintain acceptable performance in PT studies on a semiannual schedule. If an accredited laboratory fails to maintain a record of passing two out of the most recent three PT studies, it may be subject to loss of accreditation for one or more fields of accreditation. A laboratory that is out of compliance with this PT requirement may chose to participate in a Supplemental PT Study for Demonstrating Corrective Action. Corrective Action PT samples must meet the following criteria:				
18	2.7.3.1(a) The sample must be obtained from a PT Provider that meets the accreditation requirements of NELAC.				

19	<i>2.7.3.1(b) The sample must be from a lot that has met all requirements of Chapter 2 and associated Appendices. PT samples from previously released NELAC compliant PT studies may be used as long as they are within the stability period for that sample.</i>				
20	<i>2.7.3.1(c) The PT provider cannot supply the laboratory with a sample that has been previously sent to the laboratory. The original sample tracking ID must be masked and the sample tracking ID shall be unique.</i>				
21	<i>2.7.3.1(d) The assigned values for all analytes requested by the laboratory must not be equal to zero with the exception of the qualitative PCB group and qualitative microbiology.</i>				
22	<i>2.7.3.2 A laboratory that is NELAP accredited may add fields of accreditation to its scope of accreditation. As part of the request to expand its scope of accreditation, the laboratory must submit to its Primary Accrediting Authority, results of participation in two successful PT studies. The laboratory may use results of a PT study that meets the requirements of either Section 2.7.2 or 2.7.3.1. After the accreditation request is granted, the laboratory must participate in regular semi-annual PT studies.</i>				
23	<i>2.7.4 Whenever a laboratory fails a study, it shall determine the cause for the failure and take any necessary corrective action. It shall then document in its own records and provide to the Primary Accrediting Authority both the investigation and the action taken. If a laboratory fails two out of the three most recent studies for a given field of proficiency testing, its performance is unacceptable under the NELAC PT standard for that field. The laboratory shall then meet the requirements of initial accreditation as described in Section 2.7.2.</i>				
24	<i>2.7.7 A laboratory may withdraw from a PT study for an analyte(s) or for the entire study if the laboratory notifies both the PT Provider and the Primary Accrediting Authority before the closing date of the PT study. This does not exempt the laboratory from participating in the semiannual schedule.</i>				
25	<i>2.7.8 There may be occasions when the PT Provider has shipped one or more samples for NELAP accreditation which do not meet the quality control requirements of Appendix B, and the provider has not notified all affected laboratories or AAs in a timely manner. An Accrediting Authority, upon review of summary data or other relevant documentation, may choose not to use the results of the analyte(s)/matrices to support the accreditation status of the laboratories. In order to justify not using the results, the AA shall follow procedures specified in this Section.</i>				
26	<i>3.5.2 A laboratory's refusal to admit the assessment team for an assessment will result in an automatic failure of the laboratory to receive accreditation or loss of an existing accreditation by the laboratory, unless there are extenuating circumstances that are accepted and documented by the accreditation authority. The assessment team leader must notify the AA as soon as possible after refusal of entry.</i>				
27	<i>4.1.1.1 The laboratory must have a technical director who is a full-time member of the staff and exercises actual day-to-day supervision of laboratory procedures and reporting of results.</i>				

28	<i>4.1.1.1 A technical director who is absent for a period of time exceeding 15 consecutive calendar days shall designate another full-time staff member meeting the qualifications of technical director to temporarily perform this function. If this absence exceeds 65 consecutive calendar days, the accrediting authority shall be notified in writing.</i>				
29	<i>4.1.1.1 The technical director must meet the qualifications found in Chapter Four, section 4.1.1.1 (a) through (f) and exemption language in section 4.1.1.2.</i>				
30	<i>4.1.1 When the technical director does not meet the educational requirements specified in Sec. 4.1.1.1 and 4.1.1.2, he/she must meet the qualifications given in Sec. 4.1.1 (a) through (d).</i>				
31	<i>4.1.3 (b) After being notified of deficiencies, the laboratory shall have 30 calendar days from the date of receipt of the assessment report to provide a corrective action report.</i>				
32	<i>4.1.3 (d) If the corrective action report (or a portion) is deemed unacceptable to remediate a deficiency, the laboratory shall have an additional 30 calendar days to submit a revised corrective action report.</i>				
33	<i>4.1.5 (a) Each accredited laboratory shall have a named Quality Assurance Officer or a person designated as accountable for data quality in accordance with Chapter 5.</i>				
34	<i>4.1.5 (b) Each accredited laboratory shall have a developed and maintained Quality Manual available on site, as required in Chapter 5.</i>				
35	<i>4.1.8 (e) Where there is a change in ownership All records and analyses performed pertaining to accreditation must be kept for a minimum of 5 years and are subject to inspection by the accrediting authorities during this period without prior notification to the laboratory. This stipulation is applicable regardless of change in ownership, accountability or liability.</i>				
36	<i>4.3.2 The accredited laboratory shall notify the accrediting authority of any changes in key accreditation criteria within 30 calendar days of the change. This written notification of change includes but is not limited to: the laboratory ownership, location, key personnel, and major instrumentation.</i>				
37	<i>4.6 The certificate must be returned to the accrediting authority upon loss of accreditation. However, this does not require the return of a certificate which has simply expired (reached the expiration date).</i>				
38	<i>4.6.1 The laboratory must not misrepresent its NELAP accredited fields of accreditation, methods, analytes or its NELAP accreditation status on any document.</i>				
39	<i>5.0 The laboratories must meet all the requirements set forth in NELAC, Chapter 5. Verification and documentation of this must be accomplished by comparison of the applicant accrediting authority's program requirements with the Chapter 5 checklist. The NELAP assessment team must note on the checklist that each Chapter 5 requirement is addressed by the applicant accrediting authority's program.</i>				
40	<i>6.8(a)(1) NELAP accredited laboratories must post or display their most recent NELAP accreditation certificate or their NELAP accreditation fields of testing in a prominent place in the laboratory facility.</i>				

41	6.8 (a)(2) NELAP accredited laboratories must make accurate statements concerning their NELAP accreditation fields of testing and NELAP accreditation status.				
42	6.8 (a)(3) NELAP accredited laboratories accompany the accrediting authority's name and/or the NELAC/NELAP logo with at least the phrase "NELAP accredited" and the laboratory's accreditation number or other identifier when the accrediting authority's name is used on general literature such as catalogs, advertising, business solicitations, proposals, quotations, laboratory analytical reports or other materials.				
43	6.8 (a)(4) NELAP accredited laboratories not use their NELAP certificate, NELAP accreditation status and/or NELAC/NELAP logo to imply endorsement by the accrediting authority.				
<b>B. The accrediting authority's program must meet the following NELAC standards:</b>					
44	2.7.5 If a laboratory fails a second study out of the most recent three for a given analyte, as described in Section 2.7.4, the Primary Accrediting Authority shall take action, pursuant to Chapter 4, within 60 calendar days. The Primary AA shall also determine the accreditation status for all technologies/methods for which unacceptable results were reported for the analyte(s) in each matrix.				
45	2.7.6 A Primary Accrediting Authority may specify which months that laboratories within its authority are required to participate in NELAC PT programs. If the Primary Accrediting Authority chooses to specify the months, then it shall adhere to the required semiannual schedule. If the Primary Accrediting Authority does not specify the months, then the laboratory shall determine the semiannual schedule.				
46	3.2.1 An assessor must be an experienced professional and hold at least a Bachelor's degree in a scientific discipline, or have equivalent experience in environmental laboratory assessment.				
47	3.2.1 Each assessor must satisfactorily complete a training program approved by the AA responsible for on-site assessments. Each AA shall be responsible for ensuring that the training course used to train its assessors meets the NELAC standards.				
48	3.2.1(a) The assessor training program must include participation in the NELAC Basic Training Course (Section 3.2.3.1 and Appendix A), including attainment of a passing score on the written examination for the course. <b>Note: there are two standards numbered 3.2.1(a)</b>				
49	3.2.1(b) The assessor training program must include participation in at least four actual NELAC on-site assessments under the supervision of a qualified assessor. Assessors employed by accrediting authorities (either directly or as a third party) when the authority is granted NELAP recognition (see section 6.7) are exempt from the requirement to undergo training with a qualified assessor, provided they have previously conducted four assessments and been judged proficient by the accrediting authority. <b>Note: there are two standards numbered 3.2.1(b)</b>				
50	3.2.1 (c) The assessor training program must include completion of the applicable technical training requirements for at least one field of accreditation (Section 3.2.3.2 and Appendix B). <b>Note: there are two standards numbered 3.2.1(c)</b>				

51	3.2.1 Assessors must take annual refresher/update training as defined in Section 3.2.3.3				
52	3.2.1 (a) Assessors must be familiar with the relevant legal regulations, accreditation procedures, and accreditation requirements; <b>Note: there are two standards numbered 3.2.1(a)</b>				
53	3.2.1 (b) Assessors must have a thorough knowledge of the relevant assessment methods and assessment documents; <b>Note: there are two standards numbered 3.2.1(b)</b>				
54	3.2.1 (c) Assessors must be thoroughly familiar with the various forms of records described in Section 3.5.3 - Records Review; <b>Note: there are two standards numbered 3.2.1(c)</b>				
55	3.2.1 (d) Assessors must be thoroughly cognizant of data reporting, analysis, and reduction techniques and procedures;				
56	3.2.1 (e) Assessors must have a working knowledge and be conversant with the specific tests or types of tests for which the accreditation is sought and, where relevant, with the associated sampling and preservation procedures; and				
57	3.2.1 (f) Assessors must be able to communicate effectively, both orally and in writing.				
58	3.2.2 Each assessor must sign a statement before conducting an assessment certifying that no conflict of interest exists and provide any supporting information as required by the accrediting authority. Failure to provide this information will make the proposed assessor ineligible to participate in the assessment program. (See also 6.3.2.1(i))				
59	3.3.1 Accrediting authorities must conduct a comprehensive on-site assessment of each laboratory prior to granting accreditation, except as allowed by interim accreditation (Section 4.5.1). In addition, an on-site assessment of each accredited laboratory must be completed at least every two years. Assessments may be conducted more frequently for cause, at the option of the accrediting authority.				
60	3.3.2 If directed by an accrediting authority, an assessment team must conduct follow-up assessments at laboratories where a deficiency was identified by the previous assessment. These assessments may be, but are not necessarily limited to, determining whether a laboratory has corrected its deficiency(ies), or determining the merit of a formal appeal from the laboratory.				
61	3.3.2 When deficiencies are of such severity as to possibly warrant the downgrading of a laboratory's accreditation status, any follow-up assessment that is planned or conducted must be completed and reported within thirty (30) calendar days after the receipt of the laboratory's plan of corrective action.				
62	3.3.3 When a change occurs in a laboratory's ownership, location, key personnel, or major instrumentation, notification of the accrediting authority is required within 30 days (Section 4.3.2). The accrediting authority must evaluate the significance of a change that might alter or impair the laboratory's capability and quality, and indicate to the laboratory the results of their evaluation in writing. The accrediting authority must retain records to indicate that such an evaluation was conducted.				

63	3.3.4 The accrediting authority, at its discretion, may conduct either unannounced or announced on-site assessments. The accrediting authority is not required to provide advance notice of an assessment. To the maximum extent practical, accrediting authorities, when necessary, shall work with Federal departments/agencies/contractors to obtain government security clearances for their assessors as far in advance as possible. Federal departments/agencies/ contractors shall facilitate expeditious attainment of the necessary clearances.				
64	3.4.1.1 The accrediting authority determines the number and expertise of the assessment team and support personnel that are required to conduct the on-site assessment based on the type of assessment and the scope of accreditation of the accredited or applicant laboratory.				
65	3.4.1.2 An assessment team may include technical support personnel approved by the primary accrediting authority. These individuals need not be formally qualified by the accrediting authority as assessors (Section 3.2.2). If not so qualified, these individuals must still meet the requirements of the standards concerning conflicts of interest and professional conduct. Members of the assessment team who provide technical assistance but are not qualified as assessors are not eligible to conduct interviews in the absence of the assessor nor to cite deficiencies.				
66	3.4.2 The on-site assessment must include both an appraisal of the laboratory's operations and a review of the appropriate records. The assessment for a field of accreditation must cover the complete scope of accreditation for which the laboratory seeks or maintains accreditation within the specific field of accreditation as authorized by the accrediting authority.				
67	3.4.2.1 A laboratory assessment must review the ability of the laboratory to conduct environmental testing. During a laboratory assessment, the assessment team must identify a number of samples or a recently completed or on-going project and evaluate to what extent the tests are being conducted according to the NELAC standards.				
68	3.4.2.2 The accrediting authority reviews records to determine whether the testing laboratory has maintained necessary documentation of data, the quality system, and other information to technically substantiate reports previously issued. During a records review, the assessment team will conduct an overall assessment of data and will compare data with submitted reports to determine whether the data were collected, generated, and reported following the NELAC standards.				
69	3.4.3 The assessment team, prior to initiating an on-site assessment, shall make determinations as to which laboratory records shall be reviewed prior to the actual site visit. These records, from the files of the accrediting authority, the national laboratory accreditation database, or the laboratory itself include, but are not limited to:				
70	3.4.3 (a) Copies of previous assessment reports and proficiency testing sample results;				
71	3.4.3 (b) General laboratory information such as laboratory submitted self-assessment forms, SOPs, and Quality Manual(s);				
72	3.4.3 (c) Official laboratory communications and associated records with appropriate accrediting authority staff;				

73	3.4.3 (d) Available documents from recipients of reports from the laboratory;				
74	3.4.3 (e) The laboratory's application for accreditation;				
75	3.4.3 (f) The existing program regulations (federal and state), and				
76	3.4.3 (g) The most recently approved or in use laboratory methods for which the laboratory has requested or maintains accreditation.				
77	3.4.4 Documents necessary for the assessment must be provided to the laboratory management or staff. The lead assessor must obtain copies of all forms required for the assessment, including checklist(s). In addition, the lead assessor must provide information to the laboratory on how to obtain assessment information from the accrediting authority.				
78	3.4.5 The accrediting authority has procedures in place for treating confidential business information in a safe and secure manner. EPA regulations for handling confidential business information (40CFR, Part 2, Subpart B) must be followed in NELAP matters.				
79	3.4.6 Assessors performing assessments at a federal agency or at laboratories owned and/or operated by Federal departments/agencies/ contractors may need security clearances, appropriate badging, and/or a security briefing before proceeding with the on-site assessment. Assessors shall be informed in writing of any information, including analytical data, that is controlled for national security reasons and cannot be released to the public.				
80	3.5.2 An opening conference must be conducted and shall address the following topics:				
81	3.5.2 (a) the purpose of the assessment;				
82	3.5.2 (b) the identification of the assessment team;				
83	3.5.2 (c) the primary areas that will be examined;				
84	3.5.2 (d) any pertinent records and operating procedures to be examined during the assessment and the names of the individuals in the laboratory responsible for providing the assessment team with the necessary documentation;				
85	3.5.2 (e) the roles and responsibilities of key managers and staff in the laboratory;				
86	3.5.2 (f) the procedures related to Confidential Business Information;				
87	3.5.2 (g) any special safety procedures that the laboratory may think necessary for the protection of the assessment team while in certain parts of the facility (under no circumstance is an assessment team required or even allowed to sign any waiver of responsibility on the part of the laboratory for injuries incurred by a team member during an inspection to gain access to the facility);				
88	3.5.2 (h) the standards that will be used by the assessors in judging the adequacy of the laboratory operation;				
89	3.5.2 (i) confirmation of the tentative time for the exit conference;				

90	3.5.2 (j) presentation of the assessment appraisal form to the responsible laboratory official (for submission to the accrediting authority); and				
91	3.5.2 (k) discussion of any questions the laboratory may have about the assessment process.				
92	3.5.3 Assessment team members must review laboratory records for accuracy, completeness, and the use of proper methodology. NELAC Chapter 5, Section 5.12 lists the records required for review during the assessment. The assessors must document the required elements of the records review on the NELAC assessment checklists.				
93	3.5.3 If the laboratory requests that information is confidential, the information must be treated as confidential until a ruling can be made by the accrediting authority. The laboratory must mark all confidential information. The lead assessor must handle it as required by appropriate laws and regulations.				
94	3.5.4 The assessment team members shall have the authority to conduct interviews with any/all staff, as necessary.				
95	3.5.5 The assessment team must meet with representative(s) of the laboratory following the assessment for an informal debriefing and discussion of all deficiencies identified-to-date with the possible exception of any issues of improper and/or potentially illegal activity which may be the subject of further action.				
96	3.5.5 In the event the laboratory disagrees with the findings of the assessor(s), and the team leader adheres to the original findings, the deficiencies with which the laboratory takes exception shall be documented by the team leader and included in the report to the accrediting authority for consideration. The accrediting authority makes a determination as to the validity of the contested elements.				
97	3.5.5 The assessment team must inform the laboratory representative(s) that an assessment report encompassing all relevant information concerning the ability of the applicant laboratory to comply with the accreditation requirements is forthcoming.				
98	3.5.6 The accrediting authority or its authorized third party must present an assessment report to the laboratory within thirty (30) calendar days of the assessment. The laboratory has thirty (30) calendar days from the date of receipt of the report to provide a plan of corrective action to the accrediting authority (see Section 4.1.3). An exception to these deadlines is in those circumstances where a possible enforcement investigation or other action has been initiated.				
99	3.5.7 After reviewing the assessment report and any completed corrective action(s) reported by the laboratory, the accrediting authority will make the determination of the accreditation status for a laboratory. If the deficiencies listed in the initial assessment report are substantial or numerous, an additional on-site assessment may be conducted before a final decision for accreditation following the procedures of the accrediting authorities.				
	3.6.1 The following areas are to be evaluated against the standards detailed in Chapter 5, Quality Systems, Chapter 2, Proficiency Testing and Chapter 4, Accreditation Process of the NELAC Standards and the appropriate method references during an on-site assessment to determine the competence of an environmental laboratory:				

100	3.6.1(a) Organization and Management				
101	3.6.1(b) Quality System - Establishment, Assessments, Essential Quality Controls and Data Verification				
102	3.6.1(c) Personnel				
103	3.6.1(d) Physical Facilities - Accommodation and Environment				
104	3.6.1(e) Equipment and Reference Materials				
105	3.6.1(f) Measurement Traceability and Calibration				
106	3.6.1(g) Test Methods and Standard Operating Procedures				
107	3.6.1(h) Sample Handling, Sample Acceptance Policy and Sample Receipt				
108	3.6.1(i) Records				
109	3.6.1(j) Laboratory Report Format and Contents				
110	3.6.1(k) Subcontracting of Analytical Samples				
111	3.6.1(l) Outside Support Services and Supplies				
112	3.6.1(m) Complaints				
113	3.6.2 During the assessment, sufficient information may become available to suspect that a particular person has violated an environmental law or regulation, such as knowingly making a false statement on a report. This information must be carefully documented since further action may be necessary. In the event that evidence of improper and/or potentially illegal activities have or may have occurred, the assessment team must present such information to the accrediting authority for appropriate action(s). These issues, at the discretion of the accrediting authority, may or may not be subjects or issues of the closing conference. However, the assessor must continue to gather the information necessary to complete the accreditation assessment.				
114	3.6.3 Standardized checklists must be used for the on-site assessment.				
115	3.6.4 Professional standards apply to every NELAC assessor, whether a government employee or an employee of a third party organization conducting assessments under an agreement with a NELAP accrediting authority. Assessors that knowingly engage in unprofessional activity may be liable for punitive actions as initiated by the affected accrediting authority. Standards for Professional Conduct outlined in this section are based upon 5 CFR 2635 (Standards of Ethical Conduct for Employees of the Executive Branch) and will be followed in NELAP related matters. NELAC assessors shall:				
116	3.6.4(a) have no interest at play other than that of the accrediting authority and NELAC during the entire accreditation process;				
117	3.6.4(b) act impartially and not give preferential treatment to any organization or individual;				
118	3.6.4(c) provide equal treatment to all persons and organizations regardless of race, color, religion, sex, national origin, age, and/or disability;				
119	3.6.4(d) not use their position for private gain;				

120	3.6.4(e) not solicit or accept any gift or other item of monetary value from any laboratory, laboratory representative, or any other affected individual or organization doing business with, or affected by, the actions of the assessor's employer or accrediting authority;				
121	3.6.4(f) not hold financial interests that conflict with the conscientious performance of their duties;				
122	3.6.4(g) not engage in financial transactions using information gained through their positions as assessors to further any private interest;				
123	3.6.4(h) not engage in employment activities (seeking or negotiating for employment) or attempt to arrange contractual agreements with a laboratory that would conflict with their duties and responsibilities as an assessor;				
124	3.6.4(i) not knowingly make unauthorized commitments or promises of any kind purporting to bind the affected accrediting authority and,				
125	3.6.4(j) attempt to avoid any actions that could create even the appearance that they are violating any of the standards of professional conduct outlined in this section.				
126	3.6.4 It is the assessors' responsibility to report to the affected accrediting authority any personal issues or activities that constitute a conflict of interest before an assessment occurs. It is up to the affected accrediting authority to determine if the reported issues and activities regarding a specific assessor constitute, or be construed as, a conflict of interest. Appeals of decisions made by accrediting authorities regarding such matters must be directed to the Executive Director of the NELAC, who shall make the final decision as to the merit of such appeals.				
127	3.7.1 The checklists used by the assessors during the assessment shall become a part of the permanent file kept by the accrediting authority for each laboratory. The assessor shall specify the laboratory records, documents, equipment, procedures, or staff evaluated and the observations that contributed to the evaluation of "No" for each assessment checklist item. This information must be documented in the comments section or referenced on the checklist. The assessment report must contain sufficient evidence to support all assessment findings and the overall evaluation of the laboratory.				
128	3.7.2 The final assessment report shall be written to contain a description of the adequacy of the laboratory as it relates to the assessment standards in Section 3.6.1. Assessment reports must be generated in a narrative format. Documentation of existing conditions at the laboratory must be included in each report to serve as a baseline for future contacts with the facility. Assessment reports must contain:				
129	3.7.2(a) Identification of the organization assessed (name and address),				
130	3.7.2(b) Date of the assessment,				
131	3.7.2(c) Identification and affiliation of each assessment team member,				
132	3.7.2(d) Identification of participants in the assessment process,				
133	3.7.2(e) Statement of the objective of the assessment,				

134	3.7.2(f) Summary,				
135	3.7.2(g) Assessment, findings (deficiencies) and requirements.				
136	3.7.2 The Findings and Requirements section must be referenced to the NELAC standards so that both the finding (deficiency) is understood and the specific requirement is outlined. The team leader shall assure that the results within the final assessment report conform to established standards for the evaluated parameters.				
137	3.7.3 The accrediting authority shall be recognized as having the responsibility for the distribution of the assessment reports. The assessment team leader shall compile, edit, and submit the final report to the accrediting authority.				
138	<p>3.7.4 On-site assessment reports must be released initially by the accrediting authority only. The reports will be released to the responsible laboratory official(s). The assessment report shall not be released to the National Accreditation Database and the public until findings of the assessment and the corrective actions have been finalized, all Confidential Business Information and information related to national security has been stricken from the report in accordance with prescribed procedures, and the report has been provided to the laboratory (Section 4.1.3).</p> <p>In accordance with the Freedom of Information requirements, any documentation adjudged to be proprietary, financial and/or trade information, or relevant to an ongoing enforcement investigation, must be considered exempt from release to the public.</p>				
139	3.7.5 Copies of all assessment reports, checklists, and laboratory responses must be retained by the accrediting authority for a period of at least five (5) years, or longer if required by specific State or Federal regulations. (See Sections 4.3.3 & 5.12.2(b))				
140	4.0(a) Laboratories applying for accreditation may be fixed-base or mobile. The primary accrediting authority shall determine what constitutes an individual fixed-base laboratory when noncontiguous laboratory facilities operate under the same ownership, technical directorship, and quality system as the parent laboratory.				
141	4.0(b) The primary accrediting authority shall determine if a separate accreditation is required for a mobile laboratory that is owned by an accredited fixed-base laboratory, operates under the same quality system as the fixed-based laboratory, performs a subset of the analyses for which the fixed-base laboratory is accredited, and analyzes samples exclusively from within the state in which the parent fixed-base laboratory is located.				
142	4.0(c) Separate accreditation by the primary accrediting authority is required for a mobile laboratory that is owned by an accredited fixed-base laboratory, operates under the same a quality system as the fixed-based laboratory, performs a subset of the analyses for which the fixed-base laboratory is accredited, and analyzes samples from outside of the state in which the parent fixed-base laboratory is located.				
143	4.0(d) Separate accreditation by the primary accrediting authority is required for a mobile laboratory that is owned by a fixed-base laboratory but operates under a different quality system or performs analyses for which the parent fixed-base laboratory is not accredited.				

144	4.0(e) Separate accreditation by the primary accrediting authority is required for a mobile laboratory that is not owned and operated by a fixed-base laboratory.				
145	4.1.3 A corrective action report must be submitted by the laboratory to the primary accrediting authority in response to any assessment report received by the laboratory after an on-site assessment. The corrective action report shall include the action that the laboratory shall implement to correct each deficiency and the time period required to accomplish the corrective action. Upon the request of the primary accrediting authority documentation showing the implementation of corrective action(s) must be forwarded to the primary accrediting authority within the timeframe specified in the corrective action report.				
146	4.1.3 (a) The accrediting authority shall present a assessment report to the laboratory within 30 calendar days of the on-site assessment.				
147	4.1.3 (c) The accrediting authority shall respond to the action noted in the corrective action report within 30 calendar days of receiving it.				
148	4.1.3 (e) If the corrective action report is not acceptable to the accrediting authority after the second submittal, the laboratory's accreditation shall be revoked pursuant to Section 4.4.3 for all or any portion of its scope of accreditation.				
149	4.1.3(f) All information included and documented in an assessment report and the corrective action report are considered to be public information and are to be released pursuant to Chapter 3, Section 3.7.4.				
150	4.1.3 (g) If the laboratory fails to implement corrective actions to correct deficiencies noted within the required time period, the accrediting authority shall revoke the laboratory's accreditation for the affected fields of testing, methods and analytes.				
151	4.1.3(h) Proprietary data, Confidential Business Information and classified national security information will be excluded from all public records.				
	4.1.7.1 An accrediting authority must include in its application form the following:				
152	4.1.7.1 (a) Legal name of laboratory				
153	4.1.7.1 (b) Laboratory mailing address				
154	4.1.7.1 (c) Billing address (if different from b)				
155	4.1.7.1 (d) Name of owner				
156	4.1.7.1 (e) Address of owner				
157	4.1.7.1 (f) Location (full address) of laboratory				
158	4.1.7.1 (g) Name and phone number of technical director(s), however named, and the lead technical director				
159	4.1.7.1 (h) Name and phone number of Quality Assurance Officer				
160	4.1.7.1 (i) Name and phone number of laboratory contact person				
161	4.1.7.1 (j) Laboratory hours of operation				
162	4.1.7.1 (k) Primary Accrediting Authority				

163	4.1.7.1 (l) Fields of accreditation for which the laboratory is requesting accreditation				
164	4.1.7.1 (m) Methods employed including analytes				
165	4.1.7.1 (n) Description of laboratory type				
166	4.1.7.1 (o) Certification of compliance by laboratory management				
167	4.1.7.1 (p) Applicable fee enclosed (if applicable)				
168	4.1.7.1 (q) Description of geographical location				
169	4.1.7.1 (r) FAX number				
170	4.1.7.1 (s) Lab identification number				
171	4.1.7.1 (t) Unique vehicle identification number, e.g., VIN or serial number, if facility is a mobile laboratory.				
172	4.1.7.1 (u) Quality Manual				
173	4.1.7 The application package includes any specific state regulatory requirements that are essential for accreditation within an individual state.				
174	4.1.7.2 When a laboratory seeks accreditation from a secondary accrediting authority, it shall complete and submit a secondary accreditation package as required by the secondary accrediting authority.				
175	4.1.8 The accrediting authority must have procedures in place for addressing the change of ownership and/or location of an accredited laboratory that meet the requirements set forth in this subsection.				
176	4.1.9 A "Certification of Compliance" statement must accompany the application for laboratory accreditation. It must be signed and dated by both the laboratory management and the quality assurance officer, or other designated person, for that laboratory.				
177	4.1.9 The certification statement must contain at least the following statements: "The applicant understands and acknowledges that the laboratory is required to be continually in compliance with the (insert the name of the primary accrediting authority) standards and is subject to the enforcement and penalty provisions of that accrediting authority.				
178	4.1.9 "I hereby certify that I am authorized to sign this application on behalf of the applicant/owner and that there are no misrepresentations in my answer to the questions on this application."				
179	4.2 The period for accreditation will be 12 months and will be considered to be ongoing once a laboratory has been accredited for that field of testing method or analyte within a field of testing and is compliant with the NELAC standards.				
180	4.3.1 The accrediting authority determines that each laboratory has a quality system, as required by Chapter 5.				
	4.4.1 An accrediting authority shall <i>deny</i> an initial application for accreditation for the following reasons:				
181	4.4.1 (a)(1) Failure to submit a completed application.				
182	4.4.1 (a)(2) Failure to pay required fees (if applicable to the accrediting authority).				

183	4.4.1 (a)(3) Failure of laboratory staff to meet the personnel qualifications of education, training and experience as required by the NELAC standards.				
184	4.4.1(a)(4) Failure to successfully analyze and report proficiency testing samples as required by the NELAC standards, Chapter 2.				
185	4.4.1 (a)(5) Failure to respond to an assessment report from the on-site assessment with a corrective action report within the required 30 calendar days after receipt of the assessment report.				
186	4.4.1 (a)(6) Failure to implement the corrective actions detailed in the corrective action report within the specified time frame as required by the primary accrediting authority.				
187	4.4.1 (a)(7) Failure to implement a quality system as defined in Chapter 5.				
188	4.4.1 (a)(8) Failure to pass required on-site assessment(s) as specified in the NELAC standards, Chapter Three.				
189	4.4.1 (a)(9) Misrepresentation of any fact pertinent to receiving or maintaining accreditation.				
190	4.4.1 (a)(10) Denial of entry during normal business hours for an on-site assessment as required by the NELAC standards, Chapter 3.				
191	4.4.1 (b) If the laboratory is not successful in correcting the deficiencies as required by the NELAC standards, the accrediting authority shall make the laboratory wait six months before again reapplying for accreditation.				
192	4.4.1 (d) No laboratory's accreditation will be denied without the right to due process.				
193	4.4.2 (a) A laboratory's accreditation may be suspended in total or in part. The laboratory shall retain accreditation for the field of accreditations, methods and analytes where it continues to meet the requirements of the NELAC standards.				
	4.4.2 (b) An accrediting authority shall suspend a laboratory's accreditation for the following reasons:				
194	4.4.2 (b)(1) If the primary accrediting authority finds during the on-site assessment that the public interest, safety or welfare imperatively requires emergency action.				
195	4.4.2 (b)(2) Failure to complete PT studies and maintain a history of at least two successful PT studies for each affected accredited field of accreditation (as defined in NELAC, Chapter 2) out of the most recent three PT studies.				
196	4.4.2 (b)(3) Failure to notify the primary accrediting authority of any changes in key accreditation criteria, as set forth in subsection 4.3.2.				
197	4.4.2(b)(4) Failure to maintain a Quality System as defined in Chapter 5.				
198	4.4.2(b)(5) Failure of laboratory to employ staff that to meet the personnel qualifications for education, training and experience as required by the NELAC standards.				
199	4.4.2 (c) The accrediting authority does not allow a suspended laboratory to continue to analyze samples for the affected fields of testing for which it holds accreditation.				

200	4.4.2 (d) The laboratory's suspended accreditation status will change to accredited when the laboratory demonstrates to the primary accrediting authority that the laboratory complies with the NELAC standards.				
201	4.4.2 (e) The accrediting authority does not require a suspended laboratory to reapply for accreditation if the cause/causes for suspension are corrected within six months.				
202	4.4.2 (f) The accrediting authority revokes accreditation in total or in part if the laboratory fails to correct the causes of suspension within 6 months after the effective date of the suspension.				
203	4.4.2 (g) No laboratory's accreditation shall be suspended without the right to due process as set forth by the accrediting authority.				
204	4.4.3 (a) The accrediting authority shall revoke a laboratory's accreditation, in part or in total for failure to correct the deficiencies as set forth in subsection 4.1.3 (e) and failure to correct reasons for suspension. The laboratory shall retain those areas of accreditation where it continues to meet the requirements of the NELAC standards.				
	4.4.3 (b) Reasons for revocation of accreditation in part or in total shall include a laboratory's:				
205	4.4.3 (b)(1) Failure to submit an acceptable corrective action report, and implement corrective action(s) related to any deficiencies found during a laboratory assessment. in response to an assessment report.				
206	4.4.3 (b)(2) After being suspended due to failure of proficiency testing samples, if the laboratory's analysis of the next proficiency testing study results in 3 consecutively failed proficiency testing studies, the laboratory's accreditation shall be revoked for each affected accredited field of accreditation as defined in NELAC Chapter 2.				
	4.4.3 (c) Reasons for total revocation of accreditation include a laboratory's:				
207	4.4.3 (c)(1) Failure to respond with a corrective action report within the required 30 calendar days.				
208	4.4.3 (c)(2) Failure to participate in a proficiency testing program as required by the NELAC standards, Chapter 2.				
209	4.4.3 (c)(3) Submitting proficiency test sample results generated by another laboratory as its own.				
210	4.4.3 (c)(4) Misrepresentation of any material fact pertinent to receiving or maintaining accreditation.				
211	4.4.3 (c)(5) Denial of entry during normal business hours for an on-site assessment.				
212	4.4.3 (c)(6) Conviction of charges for the falsification of any report of or relating to a laboratory analysis.				
213	4.4.3 (c)(7) Failure to remit the accreditation fees within the time limit as established by the accrediting authority.				
214	4.4.3(d) No laboratory's accreditation will be revoked without the right to due process as set forth by the accrediting authority.				

215	4.4.4 The accrediting authority has provisions to allow an accredited laboratory to withdraw its accreditation. The written notification to withdraw must be received by the accrediting authority no later than 30 days before the end of the laboratory's accreditation year.				
216	4.5.1 If a laboratory completes all of the requirements for accreditation except that of an on-site assessment because the accrediting authority is unable to schedule the assessment, the accrediting authority may issue an interim accreditation. Interim accreditation shall allow a laboratory to perform analyses and report results with the same status as an accredited laboratory until the on-site assessment requirements have been completed. Interim accreditation status shall not exceed twelve months. The interim accreditation status is a matter of public record and shall be entered into the national database.				
217	4.5.2 Revocation of interim accreditation may be initiated for due cause as described in Sec. 4.3.3 by order of the primary accrediting authority.				
218	4.6 When a participating laboratory has met the requirements specified for receiving accreditation, the laboratory shall receive a certificate awarded on behalf of the accrediting authority. The certificate shall be signed by a member of the accrediting authority and shall be considered an official document. It will be transmitted as a sealed and dated (effective date and expiration date) document containing the NELAC insignia. The certificate shall include: a) name of laboratory, b) address of the laboratory, c) fields of accreditation (matrix-technology/method-analyte/analyte group), and, d) addenda or attachments (these shall be considered to be official documents).				
219	4.6 The laboratory must have a certificate for each State or federal department/agency in which it is accredited.				
220	4.6 The accrediting authority shall issue certificates which state that "continued accredited status depends on successful ongoing participation in the program".				
221	4.6 The accrediting authority shall issue certificates shall include a statement that urges a customer to verify the laboratory's current accreditation standing within a particular accrediting authority.				
222	4.6 If an accrediting authority changes a laboratory's scope of accreditation, a new certificate will be issued which details the laboratory's scope of accreditation.				
223	4.6.2 An accrediting authority may approve a laboratory's application to add an analyte or method to its scope of accreditation by performing a data review, without an on-site assessment. An addition to the scope of accreditation via a data review of proficiency testing performance (if available), quality control performance, and written standard operating procedure is at the discretion of the accrediting authority. An addition of a new technology or test method requiring specific equipment may require an on-site assessment.				
224	6.2(a) The accrediting authority is a Territorial, State, or Federal governmental organization.				
225	6.2(b) The accrediting authority has been designated as the appropriate agency or department for the fields of testing for which NELAP recognition is being sought.				

226	6.2(c) The authority for granting, maintaining, suspending or revoking a laboratory's NELAP accreditation resides with the accrediting authority.				
227	6.2(d) The accrediting authority shall administered its program in an impartial and non-discriminatory manner. The accrediting authority has no rules, regulations, procedures or practices that:				
228	6.2(d)(1) restrict the size, large or small, of any laboratory seeking accreditation.				
229	6.2(d)(2) require membership or participation in any laboratory or other professional association.				
230	6.2(d)(3) impose any financial conditions or restrictions for participation in the accreditation program other than the fees authorized by territorial, state or federal law.				
231	6.2(d)(4) conflict with any territorial, state or federal laws governing discrimination.				
232	6.2(e) The accrediting authority and its contractors shall confine their requirements, assessments and decision making processes for an accredited laboratory to those matters specifically related to the fields of testing of the accreditation being sought by a laboratory.				
233	6.2(f) The NELAP-recognized accrediting authority accompanies the display of the NELAP insignia with at least the phrase "NELAP-recognized". (Not applicable to Initial Applications)				
234	6.2 (g) Accrediting authorities, within the scope and applicability of their prevailing rules and regulations, shall establish one or more technical committees for assistance in interpretation of requirements and for advising the accrediting authority on the technical matters relating to the operation of its environmental laboratory accreditation program.				
235	6.2 (g)(1) The accrediting authority shall have formal rules and structures for the appointment and operation of committees involved in the accreditation process and such committees shall be free from any commercial, financial, and other pressures that might influence decisions, or				
236	6.2 (g)(2) The accrediting authority shall have a structure where committee members are chosen to provide relevant competent technical support and impartiality through a balance of interests where no single interest predominates, and				
237	6.2 (g)(3) The accrediting authority shall have a mechanism for publishing interpretations and recommendations made by these committees.				
238	6.2.1(a) As a NELAP-recognized secondary accrediting authority, accreditation shall be granted to laboratories accredited by any other NELAP-recognized primary accrediting authority.				
239	6.2.1(a) The NELAP-recognized accrediting authority grants such reciprocal accreditations on a laboratory-by-laboratory basis.				
240	6.2.1(a) The NELAP-recognized secondary accrediting authority consider only the current certificate of accreditation issued by the NELAP-recognized primary accrediting authority.				

241	6.2.1(b)(1) When granting reciprocal accreditation to a laboratory, the NELAP-recognized secondary accrediting authority grants reciprocal accreditation for only the fields of testing, methods and analytes for which the laboratory holds current primary NELAP accreditation.				
242	6.2.1 (b)(2) When granting reciprocal accreditation to a laboratory, the NELAP-recognized secondary accrediting authority shall grant reciprocal accreditation and issue certificates, as required in NELAC, Chapter Four, to an applicant laboratory within 30 calendar days of receipt of the laboratory's application.				
243	6.2.1(d) The NELAP-recognized secondary accrediting authority does not require any additional proficiency testing, quality assurance, or on-site assessment requirements for the fields of testing for which the laboratory holds primary NELAP accreditation.				
244	6.2.1 (e) If a NELAP-recognized secondary accrediting authority notes any potential nonconformance with the NELAC standards by a laboratory during the initial application process for reciprocal accreditation, or for a laboratory that already has been granted NELAP accreditation through reciprocity, the NELAP-recognized secondary accrediting authority shall immediately notify, in writing, the applicable NELAP-recognized primary accrediting authority and the laboratory. However, the laboratory is to be notified only in situations where no administrative or judicial prosecution is contemplated. The notification must cite the applicable sections within the NELAC standards for which nonconformance by the laboratory has been noted.				
245	6.2.1 (e) (1) If the alleged nonconformance is noted during the initial application process for reciprocal NELAP accreditation, final action on the application for reciprocal NELAP accreditation shall not be taken until the alleged nonconformance issue has been resolved.				
246	6.2.1 (e) (2) If the alleged nonconformance is noted after reciprocal NELAP accreditation has been granted, the laboratory shall maintain its current NELAP accreditation status until the alleged nonconformance issue has been resolved.				
247	6.2.1 (f)(1) Upon receipt of the subsection 6.2.1 (e) notification, the NELAP-recognized primary accrediting authority shall review and investigate the alleged nonconformance,				
248	6.2.1 (f)(2) Upon receipt of the subsection 6.2.1 (e) notification, the NELAP-recognized primary accrediting authority shall take appropriate action on the laboratory as set forth by the NELAC standards, including the addition of any change of accreditation status in the National Environmental Laboratory Accreditation Database. All such actions shall be taken in accordance with the laboratory's right to due process as set forth in the NELAC standards, Chapter Four, Accreditation Process,				
249	6.2.1 (f)(3) Upon receipt of the subsection 6.2.1 (e) notification, the NELAP-recognized primary accrediting authority shall respond to the NELAP-recognized secondary accrediting authority, in writing, with a copy to the NELAP Director, within 20 calendar days of receipt of the subsection 6.2.1 (e) notification providing: A) an initial report of the findings; B) a description of the actions to be taken; and, C) a schedule for implementation of further action on the alleged nonconformance, if necessary.				

250	6.2.1 (g) If, in the opinion of the secondary accrediting authority, the primary accrediting authority does not take timely and appropriate action on the complaint, the secondary accrediting authority should notify the NELAP Director of the dispute between the two accrediting authorities regarding proper disposition of the complaint. (See also §6.3.2.1 (o))				
251	6.2.2 (i) In order that all laboratory applications for NELAP accreditation are treated equally, accrediting authorities shall initiate processing applications for NELAP accreditation in the chronological order that the applications are received.				
252	6.2.3 (a) (1) (i) The accrediting authority has information setting forth its authority to grant laboratory accreditations and whether such laboratory accreditation is mandatory or voluntary.				
253	6.2.3 (a) (1) (ii) The accrediting authority has information setting forth its requirements for an environmental laboratory to become accredited.				
254	6.2.3 (a) (1) (iii) The accrediting authority has information setting forth the accrediting authority's assessor training and ongoing internal audit program				
255	6.2.3 (a) (1) (iv) The accrediting authority has a list of names of the qualified assessors and a list of technical support personnel (as defined in 3.4.1.2) with areas of responsibility, education and experience.				
256	6.2.3(a)(1)(v) The accrediting authority has information stating the requirements for granting, maintaining, withdrawing, suspending or revoking laboratory accreditation.				
257	6.2.3(a)(1)(vi) The accrediting authority has information about the laboratory accreditation process.				
258	6.2.3(a)(1)(vii) The accrediting authority has information on fees charged to applicants and accredited laboratories.				
259	6.2.3(a)(1)(viii) The accrediting authority has information regarding the rights and duties of accredited laboratories.				
260	6.2.3(a)(1)(ix) The accrediting authority has information listing its accredited laboratories describing the accreditation granted.				
261	6.2.3(a)(2) The accrediting authority reviews the document or documents listed in 6.2.3 (a)(1)(A through G) annually. A written record of this review is available for inspection.				
262	6.2.3(b) The accrediting authority updates the 6.2.3(a) documents when its review reveals that the program has changed or is otherwise different within 30 days of the review.				
263	6.2.3(c) The accrediting authority makes the 6.2.3(a) documents readily available upon request.				
264	6.2.3 (d) The accrediting authority shall have arrangements, consistent with NELAC, Chapter Three, On-Site Assessment to safeguard information claimed by the laboratories as confidential.				
265	6.3.2.1(b) The accrediting authority is a legally identifiable governmental entity.[See also 6.2(a) above]				
266	6.3.2.1(c) The accrediting authority has the authority, rights and responsibilities necessary to carry out an environmental laboratory accreditation program.				

267	6.3.2.1(d) The accrediting authority has the same arrangements to cover liabilities and workman's compensation claims arising from its operations and activities as all other programs, units, divisions, bureaus, etc. in the department or agency in which the accrediting authority is located.				
268	6.3.2.1(e) The accrediting authority shall have financial stability and the physical and human resources required for the operation of an accrediting authority's laboratory accreditation program. The accrediting authority shall have and make available on request a description of the means by which it receives its financial support. As a benchmark, the accrediting authority shall have the resources necessary to complete action on a laboratory's application within nine months from the time a completed application is first received from the laboratory. This time period applies as long as all turn-around times for responses to application review, proficiency testing and on-site assessment issues are carried out within the required time limits set forth in the NELAC standards.				
269	6.3.2.1(f) The accrediting authority appoints and maintain records on assessors, including contractual assessors, who meet the education, experience and training requirements set forth in the NELAC standards, Chapter three, On-Site Assessment. Such records include:				
270	6.3.2.1(f)(1) name and address.				
271	6.3.2.1(f)(2) organization affiliation and position held.				
272	6.3.2.1(f)(3) educational qualification and professional status.				
273	6.3.2.1(f)(4) work experience.				
274	6.3.2.1(f)(5) training applicable to laboratory accreditation.				
275	6.3.2.1(f)(6) experience in laboratory assessment, together with field of competence.				
276	6.3.2.1(f)(7) date of most recent updating of record.				
277	6.3.2.1(g) The accrediting authority has a system in place to evaluate assessor performance that is consistent with the organizational employee evaluation program and demonstrates compliance with the NELAC standards, Chapter three, On-Site Assessment.				
278	6.3.2.1(h) The accrediting authority has identified one individual responsible for day-to-day management of the accrediting authority's environmental laboratory accreditation program. This individual must:				
279	6.3.2.1(h)(1) be an employee of the accrediting authority.				
280	6.3.2.1(h)(2)(i) has the technical expertise necessary to plan and manage the laboratory accreditation program.				
281	6.3.2.1(h)(2)(ii) has the technical expertise necessary to coordinate various facets of the laboratory accreditation program with other territory, state and federal accrediting authorities.				
282	6.3.2.1(h)(2)(iii) has the technical expertise necessary to coordinate development of environmental laboratory accreditation regulations.				
283	6.3.2.1(h)(2)(iv) has the technical expertise necessary to evaluate the technical competence and performance of contractors or employees.				

284	6.3.2.1(i) The accrediting authority has arrangements to ensure that its management and technical staff are free of any commercial, financial or other pressures that influence the results of the accreditation process and are subject to the same conflict of interest disclosure requirements designed to identify and eliminate potential conflict-of-interest problems as all other programs, units, divisions, bureaus etc. in the department or agency in which the accrediting authority is located				
285	6.3.2.1(j) The accrediting authority has a documented procedure in place to conduct systematic internal audits annually of the accrediting authority's environmental laboratory accreditation program to verify compliance with the NELAC standards. One element of the annual internal audit shall be to review the effectiveness of the quality systems required in subsection 6.3.3.1.3. When applicable, the accrediting authority shall use the same policies and procedures for internal audits as used by all other programs, units, divisions, bureaus etc. in the department or agency in which the accrediting authority is located.				
286	6.3.2.1(k) The accrediting authority has designated the individual specified in subsection 6.3.2.1 (h) or an individual who reports directly to the individual responsible for day-to-day management of the accrediting authority's environmental laboratory accreditation program to take responsibility for the quality system and maintenance of the quality documentation required in subsection 6.3.2.1.3.				
287	6.3.2.1(l) The accrediting authority has established SOPs for dealing with appeals, complaints and disputes arising from denial, suspension or revocation of laboratory accreditation, or from users of the services about the accredited laboratories or any other matters.				
288	6.3.2.1(m) The accrediting authority requires NELAP-accredited laboratories to participate in a proficiency testing program meeting the requirements of the NELAC standards, Chapter two, Proficiency Testing Appendix A.				
289	6.3.2.1 (n) The accrediting authority or its contractors shall not offer consultancy or other services which may compromise the objectivity or impartiality of its accreditation process and decisions.				
290	6.3.2.1 (o) The accrediting authority shall have a documented procedure to address 6.2.2(g).				
291	6.3.2.1.1(a) The accrediting authority has arrangements to establish and maintain records for each accredited laboratory with respect to all aspects of the laboratory's accreditation process.				
292	6.3.2.1.1(b) The accrediting authority has a policy and procedure for retaining NELAP accreditation records for a minimum of ten years or a longer period of time if required by contractual obligations or pertinent territorial, state or federal laws and regulations.				
293	6.3.2.1.1(c) The accrediting authority has a policy and procedures concerning access to records as prescribed by the territorial, state or federal entity in which the accrediting authority resides.				
294	6.3.2.1.1(d) The accrediting authority shall have a policy and procedure for updating the NELAP national database with the NELAP-required information specific to the laboratories for which that accrediting authority is the primary or secondary accrediting authority. These updates must occur no less frequently than every two weeks. The schedule for the updates would include submitting a report even if there were no changes to the database.				

295	6.3.2.1.2(a) The accrediting authority shall have arrangements to ensure and require by signed contract or other similar type of binding document that all laboratory accreditation functions performed by a contractor on behalf of the accrediting authority are carried out in compliance with the NELAC standards.				
296	6.3.2.1.2(b)(1) When laboratory accreditation functions are contracted out, the accrediting authority takes full responsibility for such subcontracted work.				
297	6.3.2.1.2(b)(2) When laboratory accreditation functions are contracted out, the accrediting authority ensures that the contractor or his employees are competent and comply with the applicable provisions of the NELAC standards.				
298	6.3.2.1.2(b)(3) When laboratory accreditation functions are contracted out, ensure that the contractor and their employees comply with the confidentiality requirements of the accrediting authority and NELAC, and,				
299	6.3.2.1.2(b)(4)(i) When laboratory accreditation functions are contracted out, the accrediting authority ensures that the contractor and their employees are not directly involved with the laboratory seeking NELAP accreditation from the accrediting authority employing the contractor.				
300	6.3.2.1.2(b)(4)(ii) When laboratory accreditation functions are contracted out, the accrediting authority ensures that the subcontractor and their employees are not directly involved with any other affiliations which would compromise impartiality in the laboratory accreditation process.				
301	6.3.2.1.3(a) The accrediting authority has a quality system appropriate to the type, range and volume of work performed.				
302	6.3.2.1.3(b) The accrediting authority documents its quality system in a quality manual and associated written quality procedures and makes these documents available for use by the staff. The quality manual shall include at least the following:				
303	6.3.2.1.3(b)(1) the quality policy statement, including objectives and commitments, signed by the manager responsible for day-to-day management of the environmental laboratory accreditation program.				
304	6.3.2.1.3(b)(2) the organizational structure of its environmental laboratory accreditation program and the responsibilities of individual staff assigned to the structure.				
305	6.3.2.1.3(b)(3) the policies and procedures for acquiring, training, supervising and evaluating the performance of contractors carrying out any part of the accrediting authority's laboratory accreditation program.				
306	6.3.2.1.3(b)(4) the arrangements for annual internal audits, including Quality Systems reviews, as required in subsection 6.3.2.1(j).				
307	6.3.2.1.3(b)(5) the system for providing feedback to personnel responsible for the area audited and for taking timely and appropriate corrective actions whenever discrepancies are detected.				
308	6.3.2.1.3(b)(6) the procedures established to address conflict-of-interest questions arising from the NELAC standards as set forth in subsection 6.2.2 (d)(2) [Reference not currently in Section 6] and for the accrediting authority's management and technical staff as set forth in subsection 6.3.2.1(i).				

309	6.3.2.1.3(b)(7) the policies and procedures established to maintain document control.				
310	6.3.2.1.3(b)(8) the procedures and policies to implement the accreditation process.				
311	6.3.2.1.3(b)(9) the procedures and policies for dealing with appeals, complaints and disputes by laboratories.				
312	6.3.2.1.3(b)(10) the policies and procedures for dealing with reports of questionable laboratory practices				
313	6.3.4(a)(1) For all changes in the accrediting authority's environmental laboratory accreditation program listed below, the NELAP Director shall be notified of changes to: the authority to accredit laboratories as stated in the statutes, regulations and promulgating instructions establishing and governing the accrediting authority's environmental laboratory accreditation program.				
314	6.3.4 (a)(2) For all changes in the accrediting authority's environmental laboratory accreditation program listed below, the NELAP Director shall be notified of changes to: the organizational structure including key personnel.				
315	6.3.4 (a)(3) For all changes in the accrediting authority's environmental laboratory accreditation program listed below, the NELAP Director shall be notified of changes to: the rules, regulations, policies, guidance documents and standard operating procedures.				
316	6.3.4 (a)(4) For all changes in the accrediting authority's environmental laboratory accreditation program listed below, the NELAP Director shall be notified of changes to: the mailing address and office location, telephone and telefacsimile numbers and electronic mail address.				
317	6.3.4 (a)(5) For all changes in the accrediting authority's environmental laboratory accreditation program listed below, the NELAP Director shall be notified of changes to: the contractual arrangements, including contractor's personnel, for laboratory accreditation activities contracted out under authority of subsection 6.2 (c).				
318	6.3.4 (b) The notification to the NELAP Director shall be made within 30 calendar days of the change taking place in the accrediting authority's environmental laboratory accreditation program.				
319	6.8 (a) The accrediting authority shall have requirements for controlling the ownership, use and display of the accrediting authority's NELAP accreditation documents and for controlling the manner in which an accredited laboratory may refer to its NELAP accreditation and/or use of the NELAC/NELAP logo.				
320	6.8(b)(1) The accrediting authority has arrangements to require NELAP accredited laboratories choosing to use the accrediting authority's name, making reference to its NELAP accreditation status and/or using the NELAC/NELAP logo in any catalogs, advertising, business solicitations, proposals, quotations, laboratory analytical reports or other materials to distinguish between proposed testing for which the NELAP accredited laboratory is accredited and the proposed testing for which the NELAP accredited laboratory is not accredited.				

321	6.8(b)(2) The accrediting authority has arrangements to require NELAP accredited laboratories choosing to use the accrediting authority's name, making reference to its NELAP accreditation status and/or using the NELAC/NELAP logo in any catalogs, advertising, business solicitations, proposals, quotations, laboratory analytical reports or other materials to include the NELAP accredited laboratory's accreditation number or other identifier.				
322	6.8(c)(1) The accrediting authority has arrangements to require the NELAP accredited laboratories upon suspension, revocation or withdrawal of their NELAP accreditation to discontinue use of all catalogs, advertising, business solicitations, proposals, quotations, laboratory analytical results or other materials that contain reference to their past NELAP accreditation status and/or display the NELAC/NELAP logo.				
323	6.8(c)(2) The accrediting authority has arrangements to require the NELAP accredited laboratories upon suspension, revocation or withdrawal of their NELAP accreditation to return any certificates for NELAP accreditation to the accrediting authority.				
324	6.8(d) The accrediting authority has arrangements to take suitable actions, including legal action, when incorrect references to the accrediting authority's NELAP accreditation, misleading use of the laboratory's NELAP accreditation status and/or unauthorized use of the NELAC/NELAP logo is found in catalogs, advertisements, business solicitations, proposals, quotations, laboratory analytical reports or other materials..				

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